Cabinet for Human Resources
Department for Medicaid Services

907 KAR 1:150, Payments for alternative home and community based.services for the mentally retarded

Summary of the Department for Medicaid Services' Alternative Intermediate Service-Mental Retardation (AIS-MR) Reimbursement Manual

The Alternative Intermediate Service-Mental Retardation (AIS-MR) Reimbursement Manual is used by agency staff and participating pro of‘the Medicaid Program. This manual contains 157 pages.

Part I explains the general policies and guidelines for participat an AIS-MR provider. Part II describes the conditions, requirement procedures for reimbursement. Part III is the instructions for completion of the Annual Cost Report.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
ALTERNATIVE INTERMEDIATE SERVICES-MENTAL RETARDATION (AIS-MR) REIMBURSEMENT MANUAL

PART I

GENERAL POLICIES AND GUIDELINES

Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621

Revised 12/15/93

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SECTION 100 - INTRODUCTION

100. INTRODUCTION:

The General Policies and Guidelines and Principles of Reimbursement set forth in this manual specify the conditions, requirements, limitations and method of reimbursement for AIS-MR services to Title XIX (Medicaid) recipients.

The Principles of Reimbursement which follow include provisions which specify the allowable costs to be recognized in determining reimbursement for covered services rendered to program eligible individuals. These principles are supplemented by Title XVIII (Medicare) Principles of Reimbursement with regard to limitations on costs for those areas or issues which are not specifically set forth in this manual.

SECTION 101 - SCOPE OF SERVICES

101. SCOPE OF SERVICES:

The "Alternative Intermediate Services-Mental Retardation Services Manual", issued by the Department for Medicaid Services (DMS), specifies the scope and certain limitations with respect to reimbursable AIS-MR Services.

SECTION 102 - REQUIREMENTS AND LIMITATIONS OF PARTICIPATION

102. REQUIREMENTS AND LIMITATIONS OF PARTICIPATION:

If a provider elects to participate in the AIS/MR Program, the allowable cost, of all services provided in accordance with the requirements specified by the "Alternative Intermediate Services-Mental Retardation Services Manual" issued by the Department for Medicaid Services shall be included as a reimbursable cost of the participating AIS-MR provider and reimbursed up to the maximum established by **DMS.**

SECTION 103 - BILLABLE UNITS OF SERVICE

103. The Cabinet's methods of reimbursement shall utilize billable units of service, payment rates and annual cost reports.

A billable unit of service shall be based on either the direct professional time spent in face-to-face contact with a client while rendering a service, or the direct professional time associated with the provision of certain other services to or on behalf of a client(s). Please refer to Page 103.04 of this Section for a list of the prescribed units of service associated with each type of billable service.

Unit of Service Definitions

1 Client Day	A day shall begin at midnight and end twenty-four (24) hours later. A part day of service shall count as a full day.
1 Client Hour	A client hour shall start when a face-to-face contact starts and shall end sixty (60) minutes later for the initial unit. Beyond the initial unit, less than thirty (30) minutes shall be rounded down; thirty (30) minutes or greater shall be rounded up.
Example:	Actual time 1 hour, 20 minutes = 1 hour for statistics.

SECTION 103 - BILLABLE UNITS OF SERVICE

1/4 Client Hour	A quarter client hour shall start when a face-to-face contact starts. For those services where a unit of service is fifteen (15) minutes, the time may be rounded up or down. An initial unit of service less than fifteen (15) minutes may be billed as one (1) unit. Beyond the initial unit, service time less than 1/2 of the unit shall be rounded down; service time which is equal to or greater than 1/2 of the unit shall be rounded up.
Example:	20 minutes equals one (1) unit. 25 minutes equals two (2) units.
Monthly	Case Management Providers shall be eligible to bill for Case Management (monthly) for any calendar month in which the client receives case management (monthly) for more than 1/2 of the month.
Intake & Evaluation	An intake and evaluation period for a client shall be counted as a single unit of service. Case management intake services shall be billed for the initial evaluation of the client and for residential clients includes the first fourteen (14) days of core stay. For the first fourteen (14) days of the client's core stay or actual core stay if less, the client shall not be eligible for Case Management (monthly) services.

Cost per unit of service shall be determined by dividing the fully allocated cost for a direct service cost center by its units of service. With the exception of Case Management Services, direct service cost centers and their units of service correspond to billable services as set forth in the "Alternative Intermediate Services-Mental Retardation Services Manual."

SECTION 103 - BILLABLE UNITS OF SERVICE

For cost reporting purposes, only those costs relating to the Professional component of the initial evaluation shall be included in the Case Management(Intake Evaluation) cost center on the cost report. Units of service shall be the number of individuals for whom an initial (intake) evaluation is performed.

The Case Management (Core Cost) cost center shall include all residential (excluding room and board costs) costs incurred during either the Initial Evaluation period, during any continuing stay in the core prior to initial placement or any transition period stay in the core residence. The unit of service shall be counted as client days. The day of arrival at the core shall be counted as a client day and the day of departure shall not be counted unless it was also the day of arrival.

The Case Management (Monthly Evaluation) cost center shall include those costs related to monthly (ongoing) Case Management. Units of service for cost report purposes shall be the same as billable units of services as defined in the "Alternative Intermediate Services-Mental Retardation Services Manual."

SECTION 103 - BILLABLE UNITS OF SERVICE

STANDARD BASES FOR REPORTING UNITS OF SERVICE

TYPE OF SERVICE AIS-MR	UNIT OF SERVICE
Case Management (Intake-Evaluation)	1 Client Stay (Up to 14 Days)
Case Management (Core Cost)	1 Client Day
Case Management (Monthly)	1 Client Month
Residential Care - Group Home	1 Client Day
Residential Care - Family Home	1 Client Day
Individual Care - Staffed Residence	1 Client Day
In-Home Training	1/4 Client Hour
Homemaker-Home Health Aide	1/4 Client Hour
Personal Care	1/4 Client Hour
Day Habilitation	1 Client Hour
Adult Day Habilitation (ADH) - Supported Employment	1 Client Hour
Adult Day Habilitation (ADH) - Prevocational Services	1 Client Hour
Respite - Hourly	1 Client Hour
Respite - Daily	1 Client Day
Habilitation - Speech	1/4 Client Hour
Habilitation - Occupational Therapy	1/4 Client Hour
Habilitation - Physical Therapy	1/4 Client Hour
Habilitation - Behavior Specialist	1/4 Client Hour
Habilitation - Leisure Trainer	1 Client Hour
Habilitation - Psychological Serv.	1/4 Client Hour
Habilitation - Expressive Therapy	1/4 Client Hour
Habilitation - Therapeutic Recreation	1/4 Client Hour

104. RATE SETTING FOR PERIODS AFTER DECEMBER 31, 1993:

A final prospective payment rate shall be established effective each January 1 for each type of service on the basis of actual reasonable allowable cost as derived from the provider's audited annual cost report for the prior fiscal year. If an audited cost report is not available, the most recent unaudited annual cost report shall be the basis for the final rate. If an unaudited cost report is used to establish rates, these rates shall be adjusted upon audit or desk review of the cost report used in setting the rate.

Allowable costs shall be trended to the beginning of the rate year and indexed to the end of the rate year. The payment rate for each service area shall be the lower of the per unit rate derived from the provider's cost report or the maximum rate for that service as established by the Medicaid Program. This maximum shall be determined for each direct service department and shall be set at 130 percent of the median cost per unit of service of all participating providers.

SECTION 105 - UTILIZATION REVIEW

105. UTILIZATION REVIEW:

If deemed necessary to assure appropriate utilization, systems of utilization review for determining norms and upper limitations and acceptable deviations from standards may be established. If established, these standards shall be used to identify possible abuse of the payment system and to prospectively inform providers of the promulgation of limitations.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
ALTERNATIVE INTERMEDIATE SERVICES-MENTAL RETARDATION (AIS-MR) REIMBURSEMENTMANUAL

PART II

PRINCIPLES OF REIMBURSEMENT

Cabinet for Human Resources
275 East Main Street
Frankfort, Kentucky 40621

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SESCTION 200 - INTRODUCTION

200. INTRODUCTION :

(A) AIS-MR providers shall be reimbursed by the DMS for -- providing prior approved (by the Peer Review Organization and the Department) covered services which meet service definitions to eligible clients.

(B) The principles of reimbursement which follow establish the guidelines and procedures which shall be used in determining reasonable allowable cost.

(C) These principles of reimbursement shall be applied by the Cabinet in the payment of claims.

(D) The Cabinet may furnish technical assistance to providers in the development of accounting and cost finding procedures which shall assure them equitable payment under all programs.

SECTION 201 - COST REIMBURSEMENT - GENERAL

201. COST REIMBURSEMENT - GENERAL:

(A) All expenses of a provider in the production of services shall be necessary and proper to be considered reasonable and allowable. The share of the total provider cost that is borne by one (1) funding source shall be related to the services furnished its beneficiaries so that no part of their cost would need to be borne by any other funding source.

(B) These principles give recognition to such factors as depreciation, interest, certain educational costs, bad debts and cost to related organizations. With respect to allowable costs, some items of inclusion and exclusion are:

(1) Depreciation shall be an allowable cost. An historical cost basis shall be used. Only assets actually in use for production of services for program beneficiaries shall be recognized. A use allowance may be negotiated for fully depreciated assets. The funding of depreciation is encouraged to provide necessary replacement of

assets. The American Hospital Association Guidelines for estimating useful lives of depreciable assets shall be followed. (See: Section 206)

(2) Interest costs shall be allowable costs, with certain restrictions. (See: Section 207)

(3) Bad debts, charity, and courtesy allowances shall not be allowable costs. (See: Section 208)

(4) Costs incurred for research purposes shall not be allowable costs. (See: Section 210)

(5) Grants, gifts, and income from endowments shall not be deducted from allowable costs unless they are designated by the donor for the payment of specific costs. (See: Section 211)

(6) The value of services provided by non-paid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish the services, shall not an allowable cost.

(7) Discounts and allowances received on the purchase of goods or services shall be reductions of the cost to which they relate. (See: Section 212)

(8) The costs associated with political contributions shall not be allowable costs.

(9) The costs associated with legal fees for unsuccessful lawsuits against the Cabinet shall not be allowable costs. Legal fees relating to lawsuits against the Cabinet shall only be included as allowable costs in the period in which the suit is settled after a final decision is rendered and the lawsuit is successful in favor of the provider, or when otherwise agreed to by the parties involved, or ordered by the court.

(10) With the exception of costs associated with item (9) of this section, i.e, the cost associated with any legal expense incurred in the normal and routine administration of the program shall be an allowable cost; however, the cost of legal fees incurred for judgements granted as a result of unlawful pursuits shall not be allowable.

(11) The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities shall not be allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky shall be allowable costs. Even though the meetings per se are not educational, costs (excluding transportation) shall be allowable if educational or training components are included.

(12) costs of patient transportation shall be allowable.

(13) The costs of all motor vehicles used by management personnel shall be allowed up to twenty thousand dollars ($20,000) total valuation per vehicle. Cost exceeding this limit shall not be allowable, except when the cost is considered as salary compensation.

(14) The cost of client wages and production costs for those work programs habilitative in nature shall be allowable costs; however, the cost shall be offset by the gross revenue derived from the sale of any items produced.

(15) Program income as defined by 45 CFR Part 74, Subpart F, shall be deducted from total allowable costs unless alternative cost reporting treatment shall have been approved, in writing, by the Cabinet.

(16) costs relating to Lobbying shall be unallowable costs.

(17) Residential room and board expenses for AIS-MR clients shall not be allowable costs.

SECTION 202 - APPORTIONMENT OF ALLOWABLE COSTS

202. APPORTIONMENT OF ALLOWABLE COSTS:

(A) Reimbursement under Cabinet programs involves a determination of (1) each provider's allowable costs of providing services, and (2) the equitable allocation of these costs to be borne by the various funding sources. A provider's allowable costs shall be determined in accordance with the principles of reimbursement described relating to reasonable allowable costs. The share of a provider's allowable costs to be borne by the various funding sources shall be determined in accordance with the principles Set forth in this section, relating to the standardized allocation of costs.

(B) Methods shall be adopted which result in a funding source's share of a provider's total allowable costs being directly related to the benefits derived from each item of cost.

(C) Prescribed Cost Allocation Methods. Each provider shall directly identify (charge) expenses to cost centers whenever it is practical to do so.

If it is not practical to directly identify expenses, the provider shall develop allocation methods which shall not conflict with the following prescribed allocation methods and which utilize auditable statistics that bear direct relationship to the expense which is being allocated. The following methods of cost allocation shall be utilized when deriving cost data for the purpose of filing the annual cost reports required in Section 203 of this Manual.

(1) Cost Centers: Each provider shall establish and maintain, as a minimum, a cost accounting system which shall identify expenses by service or support activity and location.

(2) Personnel Costs (Excluding Fringe Benefits): shall be identified for each employee based on his professional time which shall be documented by time reports that reflect an after-the-fact determination of the actual activity of each employee. (Estimates shall not qualify as support for charges to services or supportive activities.) Each employee's

personnel cost shall be allocated based solely on that portion of his time which has been directly identified to two (2) or more service or support activities. Indirect time, which cannot be readily identified to service or support activities (such as: leave or idle time) shall not be included for purposes of personnel cost allocations.

(3) Fringe Benefits: shall be allocated to service or support activities based on the allocated Personnel costs of the employees to which they relate.

(4) Facility Costs: shall be accumulated for each locality (building) and allocated based on the square footage utilized by service or support activities within each location. Where the same space may be used for multiple service or support activities, an allocation of the space shall be made based on time studies which identify the actual direct hours of use for each service or-

support activity. Time studies shall be conducted only with the prior written approval of the Cabinet.

(5) Clinical Support costs (including medical records): shall be allocated at the lowest organizational level practical based on units of service, if comparable; otherwise, clinical support costs shall be allocated based on the accumulated cost of those services which have benefitted. Organization-wide clinical support costs shall be identified on Schedule B of the Annual Cost Report and allocated based on total accumulated cost in accordance with the cost report instructions (see: Part III of this Manual).

(6) Administrative Costs: shall be allocated at the lowest organizational level practical based on accumulated cost. Organization-wide administrative costs shall be identified on Schedule B of the Annual cost Report and allocated based on total accumulated cost in

accordance with the cost report instructions (see: Part III of this Manual).

(7) Client Transportation Costs: shall be identified at the lowest organization level practical and allocated to benefitting services based on the number of clients transported.

(D) If, at anytime prior to the start of the fourth quarter of any cost reporting period, a provider wishes to use a method of cost allocation which differs from the prescribed methods described in (C) above, they may do so only after receiving the prior written approval of the Cabinet. Requests for approval shall be sent to the Director, Division of Reimbursement Operations, Department for Medicaid Services. Requests for approval from Community Mental Health-Mental Retardation Centers shall be sent to the Director, Division of Audits, Office of Inspector General for dissemination to effected Cabinet departments.

SECTION 203 - FINANCIAL DATA AND REPORTS

203. FINANCIAL DATA AND REPORTS:

(A) **General.** Providers shall maintain sufficient financial records and statistical data for proper determination of costs payable by various funding sources. The cost and statistical data available from the provider's records shall be utilized to arrive at an equitable and proper payment for services to beneficiaries of each funding source.

(B) **Cost Reports.** For cost reporting purposes, each provider of services shall submit periodic reports of its operations which cover a consecutive twelve (12) month period. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Cabinet.

(C) **Due Dates for Cost Reports.** Cost reports shall be due on or before the last day of the third month (90 days) following the close of the period covered by the report. There shall be no automatic extension of time for the filing of the cost report. However, providers

may request a thirty (30) day extension of time when circumstances jeopardize timely filing. The extension shall be requested in writing five (5) days prior to the date the cost report is due. The request shall be addressed. to the Director, Division of Reimbursement Operations, Department for Medicaid Services. Payments to the provider may be suspended until an acceptable cost report is filed with the Cabinet.

(D) **Recordkeeping Requirements for New Providers. A** newly participating provider of services shall, upon request, make available to the Cabinet for examination its fiscal and other records for the purpose of determining the provider's ongoing recordkeeping capability and inform the Cabinet of the date its initial cost reporting period shall end. This examination is intended to assure that (1) the provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified

auditors and adequate for cost reporting purposes, (2) the provider's financial statements shall be audited and reported upon by a certified public accountant, and (3) no financial arrangements exist that shall obstruct the intent of the Cabinet to reimburse providers in accordance with guidelines contained herein. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement.

(E) **Providers Without a Full Year's Experience.** Providers that have recently opened for business, or who have just begun participation in one (1) or more programs and do not have twelve (12) months of actual experience, shall file a projected twelve (12) month cost report. This report shall consider actual costs and units of service, in each specific service department that have occurred since the opening of the center and project costs and units of service for the twelve (12) month period taking into consideration known factors. This projected cost report shall be reviewed to determine the reasonableness of the estimate. Adjustments shall

be made if necessary in light of the experience of similar providers.

(F) Fiscal Year. All providers shall utilize a June 30 fiscal year end for cost reporting purposes.

(G) Continuing Provider Recordkeeping Requirements. The provider shall furnish information to the Cabinet as may be necessary to assure proper payment by the Cabinet including the extent to which there is any common ownership or control between providers or other organizations.

(H) Time Record Requirements. Personnel costs whether considered direct or indirect costs, shall be based on payrolls documented and approved in accordance with. sound management practices and standard cost accounting methods. Payrolls shall be supported by time and attendance records which identify 100 percent of each individual employee's time.

(I) Access to Provider Records. The provider shall permit the Cabinet to examine records and documents as are necessary to ascertain information pertinent to

the determination of the proper amount of program payments due. These records shall be kept by the provider for a period of not less than three (3) years, or until audit resolution, whichever is longer, and shall include: (1) matters of provider ownership, organization, and operation; **(2)** minutes of meetings of Board of Directors and committees; (3) fiscal, patient treatment and other records; (4) federal income tax returns; (5) matters relating to asset acquisition, lease, sale or other dispositions; (6) franchise or management arrangements including costs of parent or "home office" operations; **(7)** client service charge schedules; **(8)** all matters pertaining to cost of operation; (9) amounts of income received by source and purpose; and (10) the flow of funds and working capital.

(J) **Suspension of** Program **Payments to a Provider.** If the Cabinet determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the program, payments to the provider may be suspended until the Cabinet is assured that adequate records

are maintained. Before suspending payments to a provider, the Cabinet shall send written notice to the provider of its intent to suspend payments. Any overpayment which may have occurred after the close of the provider's reporting period, but prior to the setting of a new rate as a result of the provider's failure to maintain adequate records, shall be recovered by the Cabinet. The notice shall explain the basis for the Cabinet's determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies. The provider shall be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension may not be put into effect.

SECTION 204 - ADEQUATE COST DATA AND COST FINDING

204. ADEQUATE COST DATA AND COST FINDING:

(A) Principle. Providers shall provide adequate cost data. This shall .be based on their financial and statistical records which shall be capable of verification. The cost data shall be based on the prescribed methods of cost finding contained in Section 202 and, unless otherwise approved in writing by the Cabinet, on accounting methods which shall be in conformity with generally accepted accounting principles.

(B) **Definitions.**

(1) **Cost Finding.** Cost finding shall be the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. Cost finding shall be the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) **Accrual Basis of Accounting.** Under the accrual basis of accounting, revenue shall be reported in the period when it is earned regardless of when it is collected, and expenses shall be reported

in the period in which they are incurred regardless of when they are paid.

(3) **Prior Approval.** Prior approval means that a provider shall secure approval, in **writing, of** a methodology change prior to implementation. Verbal approval shall not be acceptable and **shall** not be considered as prior approval.

(C) Adequacy and Consistency. Adequate cost information shall be provided in sufficient detail in the provider's records to support payments made for services rendered to beneficiaries. In order to provide the required cost data and not impair comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect the change.

205. PAYMENTS TO PROVIDERS: SPECIAL CIRCUMSTANCES

(A) **Prospective Rate Determination for New Providers.** If newly established providers do not have six (6) months of actual cost experience on which to base the determination of a prospective rate, the provider shall file a projected twelve (12) month cost report. This report shall be evaluated to determine the reasonableness of the projections and a rate determined relative to the experience of similar providers, maximum rates established by the Program, and other factors.

(B) Rate Determination for a New Service. If a provider implements a new service and does not have twelve (12) months of actual cost experience on which to determine a rate, the provider may file a budgeted report for that service, projecting costs and the number of units of services to be provided. The scope of the service and the projections shall be justified by appropriate narratives and worksheets, and prior approval shall be secured from the Cabinet before a new rate is set. A prospective rate shall be determined on the basis of

the lower of the approved projections or the maximum rate established by the Program. If at the fiscal year end, the provider does not yet have six (6) months of actual cost experience for that service, a budgeted report shall again be filed, using actual data if appropriate in arriving at a projection.

(C) Bankruptcy or Insolvency of Provider. If, on the basis of reliable evidence, the Cabinet has a valid basis for believing that, with respect to a provider, proceedings have been or shall shortly be instituted in a State or Federal court for purposes of determining whether a provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Cabinet, notwithstanding any other regulation or program instruction regarding the timing or manner of the adjustments, to a level necessary to insure that no overpayment to the provider shall be made.

SECTION 206-DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS

206. DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS:

(A) Principle. An appropriate allowance for depreciation on buildings and equipment shall be an allowable cost within the limitations specified below. The depreciation shall be:

(1) identifiable and recorded in the provider's accounting records;

(2) based on the historical cost of the asset or, in the case of donated assets, the fair market value when donated;

(3) prorated over the estimated useful life of the asset using the straight-line method; and

(4) any acquisition or improvement of a depreciable asset of at least $500 with at least a two (2) year life shall be capitalized. Repairs and maintenance to an asset shall be allowable costs in the current accounting period, except that any repair and maintenance of an asset for $2,500 or an aggregate of that amount during the reporting year shall be capitalized over the remaining useful life of the asset.

SECTION 206-DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS

(B) Definitions.

(1) Historical Costs. Historical cost shall be the cost incurred by the present owner in acquiring the asset. For depreciable assets acquired after June 1, 1978, the historical cost used as the basis for depreciation shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or fair market value at time of acquisition.

(2) Fair Market Value. Fair market value shall be the price that the asset would bring by bona fide -bargaining between well-informed buyers and sellers at the **date** of acquisition. Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market when acquired.

(3) Current Reproduction Costs. Current reproduction cost shall be the cost at current prices, in a

particular locality or market area, of -- reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to build, reproduce in kind, or in the case of equipment or similar assets, to purchase in the competitive market.

(C) Recording of Depreciation. Appropriate recording of depreciation shall encompass the identification of the depreciable assets in use, the asset's historical costs, the method of depreciation, estimated useful life, and the asset's accumulated depreciation. In selecting a proper useful life, the American Hospital Association's "Estimated useful lives of Depreciable Hospital Assets" (1988 edition) shall be used.

(D) Depreciation Methods. Proration of the cost of an asset over its useful life shall be allowed on the straight-line method.

(E) **Gains and Losses on Disposal of Assets.** Gains and losses realized from the disposal of depreciable assets while a provider is participating with the Cabinet, or within one (1) year of the time the provider terminates participation, shall be included in the determination of allowable cost. The extent to which gains and losses shall be included shall be calculated on the proration basis recognizing the amount of depreciation charged under Cabinet funding in relation to the amount of depreciation, if any, charged or assumed in the period prior to the provider's participation, and in the period after the provider's participation, if the sale takes place or within one (1) year after termination.

(F) Basis of Assets Donated to a Provider. If an asset is donated to a provider, the basis for depreciation of the asset shall be the fair market value of the asset when donated.

(G) Basis of **Assets Used Under the Program and Donated to a Provider.** If an asset that has been used or depreciated under the Program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the Program. The net book value of the asset shall be defined as the depreciable basis used under the Program by the asset's last participating owner less the depreciation recognized under the Program.

(H) Amortization of Start-Up Costs. For new service providers or newly established satellite centers of participating providers, proration of start-up costs shall be over sixty (60) months utilizing the straight-line method.

(I) Depreciation of Fully Depreciated or Partially Depreciated Assets.

(1) **Principle. Depreciation** on assets being used by a provider when it enters into participation with the Cabinet shall be allowed; this applies even

though these assets may be fully or partially depreciated on the provider's books.

(2) Application. Depreciation shall be allowable on assets being used when the provider enters into participation with CHR. This shall apply even though these assets may be fully depreciated on the provider's books or fully depreciated with respect to other third party payors. If an asset is being used, its useful life shall be considered not to have ended, and consequently the asset shall be subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by the Cabinet. Correction of prior year's depreciation to reflect revision of estimated useful life shall be made in the first year of participation. If an asset has become fully depreciated under CHR funding, further depreciation shall not be appropriate or allowable, even though the asset may continue in use. For example, if a fifty (50) year old building is in use when the

provider enters into participation, depreciation shall be allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is twenty (20) years (seventy (70) years from the date of acquisition), the provider may claim depreciation over the next twenty (20) years - if the asset is in use that long - or a total depreciation of as much as twenty-seventieths (20/70) of the asset's historical cost. If the asset is disposed of before the expiration of its estimated useful life, the depreciation shall be adjusted to the actual useful life. Likewise, a provider may have fully depreciated other assets it is using and find that it has incorrectly estimated the useful lives of those assets.

In these cases, the provider may use the corrected useful lives in determining the amount of depreciation, provided the corrections have been approved by the Cabinet.

(J) Depreciation of Assets Financed with Federal or Public Funds.

(1) **Principle.** Depreciation shall be allowed on assets financed with Federal or public funds unless specifically prohibited by the funding source's regulations.

(2) **Application.** Like other assets (including other donated depreciable assets), assets financed with Federal or public funds shall become a part of the provider's plant and equipment to be used in rendering services. If an asset is used in the provision of services for recipients of the Cabinet, payment for depreciation of the asset shall be a cost of the production of those services and shall be considered as such unless specifically prohibited by the funding source.

SECTION 206-DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS

An incentive for funding of depreciation shall be provided in these principles by the provision that investment income on funded depreciation shall not be treated as a reduction of allowable interest expense under Section 207(B)(2)c of this manual.

SECTION 207 - INTEREST EXPENSE

207. INTEREST EXPENSE:

(A) Principle. Necessary and proper interest as defined on both current and capital indebtedness shall be an allowable cost.

(B) Definitions.

(1) Interest. Interest shall be the cost incurred for the use of borrowed funds. Interest on current indebtedness shall be the cost incurred for funds borrowed for a relatively short term. This is usually for purposes as working capital for normal operating expenses. Interest on capital indebtedness shall be the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) Necessary. Necessary requires that the interest shall:

a. Be incurred on a loan made to satisfy a financial need of the provider. Loans which

result in excess funds *or* investments shall not be considered necessary.

b. Be incurred on a loan made for the following purposes:

1. Represent interest on long-term debt existing when the provider enters into participation with the Cabinet plus interest on new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of services. If the debt is subject to variable interest rates found in "balloon" type financing, renegotiated interest rates subject to tests of reasonableness shall be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one (1) year.

2. **Other interest for working capital and** operating needs that directly relate to providing patient care shall be an allowable cost with the following exception. Short-term interest expense on a principal amount in excess of payments made under the rate equivalent to two (2) months experience based on actual Cabinet funding receivables, shall be disallowed in determining cost. The form of indebtedness may include notes, advances, and various types of receivable financing.

c. Be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, **or** have been uncommingled, if necessary. This shall not mean that the

funds shall be kept in separate bank accounts, although this may be found to be the easiest method. If investment income is derived from combined or pooled funds, only that portion of investment income resulting from the facility's assets after uncommingling shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense.

For purposes Of' this section, monies received from federal or state funding sources shall not be considered 'gifts or grants. Funds shall be considered sufficiently uncommingled when the following criteria shall be met:

1. The source of the gifts and grants shall be identified and documented.
2. The receipt and disbursement of these funds shall be recorded in separate

general ledger accounts (distinguishable by sources of funds).

The balance of these funds in the general ledger accounts shall (at all times) be reconcilable with the investment account balances.

(3) Proper. Proper requires that interest shall:

a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest shall be allowable if paid on loans from the facility's donor-restricted funds, the funded depreciation accounts, or facility's qualified pension fund.

(C) Borrower-Lender Relationship.

(1) To be allowable, interest expense shall be incurred on indebtedness established with

lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors may affect the "bargaining" process that usually accompanies the making of a loan, and may thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. Interest paid by the facility to partners, stockholders, or related organizations of the facility shall not be allowable. If the owner uses his own funds in a business, the funds shall be treated as invested funds or capital, rather than borrowed funds.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds shall be made in the following circumstances.

If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense shall be an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund.

(3) If funded depreciation is used for purposes other than improvements, replacement, or

expansion of facilities or equipment related to patient care, allowable interest expense shall be reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund if the deposits are used for other than the purpose of which the fund was established.

(D) Loans Not Reasonably Related to Patient Care. Loans made to finance that portion of the cost of acquisition of a facility that exceed historical cost as determined under Section **206(B)** of this manual or the cost basis as determined under Section **206(G)** of this manual shall not be considered to be for a purpose reasonably related to patient care.

SECTION 208 - BAD DEBTS, CHARITY AND COURTESY ALLOWANCES

208. BAD DEBTS, CHARITY AND COURTESY ALLOWANCES:

(A) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.

(B) Definitions.

(1) Bad Debts. Bad debts shall be amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

(2) Charity Allowances. Charity allowances shall be reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) Courtesy Allowances. Courtesy allowances shall be reductions in charges to physicians, clergy, members of religious orders and others for services received from the provider as approved by the policies of the governing body of the provider. Employee fringe benefits, such as hospitalization and personnel health programs, shall not be considered to be courtesy allowances.

SECTION 209 - INDIRECT ADMINISTRATIVE COSTS

209. INDIRECT ADMINISTRATIVE COSTS:

(A) Definitions. The following definitions shall apply unless the specific context dictates otherwise.

(1) "Direct Costs" means those costs that can be identified specifically with and charged in whole or in part to a particular project, service, program or activity of an organization.

(2) "Indirect Costs" means those costs of an organization which are not specifically identifiable with a particular project, service, program, or activity but nevertheless are necessary to the general operation of the organization and the conduct of the activities it performs.

(3) "Administrative Activities" means those activities performed by an organization in the development and implementation of policy and the management of the organization necessary to fulfill the functions and obligations of the

organization. These activities generally include agency and personnel management, accounting, auditing, and legal services.

(4) "Service Activities" means those activities carried out by an organization which are integral and necessary to the production or delivery of specific products or services.

(5) "Indirect Administrative Costs" means those costs for administrative activities of an organization which are not specifically identifiable with a particular project, service, program or activity.

(6) "Cost Allocation Plan" means the written description of processes for identification, accumulation, and distribution of costs together with the allocation methods used.

(B) Indirect Administrative Cost Limitation in Contracts.

(1) The Cabinet for Human Resources shall limit payment to AIS-MR providers for indirect

administrative cost to no more than ten (10) percent of any provider agreement or contract total. For the purpose of this Section, provider agreement and contract total means total actual, allowable expenses reimbursable by the Cabinet.

(2) If offering a contract for bid or negotiation, the AIS-MR provider shall clearly indicate that it shall limit its reimbursement of indirect administrative cost to no more than ten (10) percent of the total actual allowable expenses. If total indirect administrative cost exceeds the limit, the additional expense shall be the responsibility of the provider and not the Commonwealth.

(3) If more restrictive contract provisions or federal or state laws or regulations apply to particular contract, the laws, regulations, or contract provisions shall prevail with respect to limitations of indirect administrative cost.

(4) If an audit results in a finding that the indirect administrative cost limitations have been exceeded for the period of performance under the contract or provider agreement, payment made by the Cabinet to the provider in consideration of the cost shall be subject to recovery from the provider by the Cabinet.

(C) Documentation Requirements for Costs.

(1) All direct or allocable direct charges shall be documented by appropriate source documents to support the direct charging of the expense.

(2) The provider shall document the method used to allocate direct or indirect costs.

(3) Reports of audits performed to meet federal or state requirements and which shall be conducted by independent public auditors, Cabinet auditors, or the State Auditor, shall contain a statement as to the compliance of the provider with the cost limitations.

(D) **Subcontracts.** If the primary contractor subcontracts with any non-state government agency or organization or individual pursuant to or relating to its contract or provider agreement with the Cabinet, the indirect administrative cost of the primary contractor shall not exceed ten (10) percent of the total actual allowable expenses reimbursed by the Cabinet excluding these subcontracted costs. The indirect administrative cost of the subcontractor shall not exceed ten (10) percent of the total actual allowable expenses reimbursed by the primary contractor to the subcontractor. Exceptions to the division of indirect administrative cost between the primary contractor and the subcontractor shall be subject to case-by-case negotiation between the Cabinet and the primary contractor. In these cases, where an exception to the limits may be deemed reasonable and justifiable, the negotiated limits together with the reasons for the exception shall be expressed in the terms and conditions of the resulting contract. No **combined indirect administrative costs of the** primary contractor and subcontractor(s) shall in the aggregate exceed ten (10) percent of the total actual allowable expenses reimbursed by the Cabinet.

SECTION 210 - RESEARCH COSTS

210. RESEARCH COSTS:

(A) Principle. Costs incurred for research purposes, over and above usual patient care, shall not be includable as allowable costs.

(B) Exception. If research is conducted in conjunction with and as part of patient services, the costs of usual patient services shall be allowable to the extent that these costs are not met by funds provided for the research. Under this principle; studies, analyses, surveys, and related activities to serve the provider's administrative and program needs shall be included as allowable costs.

SECTION 211 - GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

211. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS:

(A) Principle. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs. Unearned income shall not be deducted in the year that it is received and not earned, but shall be deducted in the year that it is earned.

(B) Definitions.

(1) Unrestricted Grants, Gifts, Income from Endowments. Unrestricted grants, gifts, and income from endowments shall be funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

(2) Designated or Restricted Grants, Gifts and Income From Endowments. Designated or restricted grants, gifts and income from endowments shall be funds, cash or otherwise, which shall be used only for the specific purpose designated by the

donor. This shall not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

(C) Application.

(1) Unrestricted funds, cash or in-kind contributions shall be considered the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs.

(2) Donor-restricted funds which are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all patients who use the services covered by the donation.

SECTION 212 - PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSE

212. PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSE:

(A) Principle. Discounts and allowances received on purchases of goods or services shall be reductions of the costs to.which they relate. Similarly, refunds of previous expense payments shall be reductions of the related expense. Reductions to cost shall be made in the same year the discount, allowance or refund is received.

(B) Definitions.

(1) Discounts. Discounts, in general, shall be reductions granted for the settlement of debts.

(2) Allowances. Allowances shall be deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) Refunds. Refunds shall be amounts paid back or credits allowed because of over collections.

SECTION 213 - COST TO RELATED ORGANIZATIONS

213. COST TO RELATED ORGANIZATIONS:

(A) Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization. However, the cost shall not exceed the price of comparable services, facilities, or supplies that may be purchased elsewhere by a prudent and cost-conscious buyer.

(B) Definitions.

(1) **Related to Provider.** Related to the provider shall mean that the provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

(2) **Common Ownership.** A relationship shall be considered to exist when an individual or individuals possess five **(5)** percent or more of the ownership or equity in the facility and the

facility and the institution or organization serving the provider.

(3) Control. Control shall exist when an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(C) Exception. An exception may be provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Cabinet: that the supplying organization is a bona fide separate organization; that fifty-one (51) percent or more of the supplier's business activity of the type carried on with the provider is transacted with persons and organizations other than the provider and its related organizations; that there is an open, competitive market for the type of services, facilities, or supplies furnished by the supplier; that the services, facilities, or supplies are those which commonly are obtained by organizations such as the provider from other organizations and are not a basic element of patient care ordinarily furnished

directly to patients by the providers; and that the charge to the provider is in line with the charge for these services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for these services, facilities, or supplies. In these cases, the charge by the supplier to the provider for these services, facilities, or supplies shall be allowable as cost.

SECTION 214 - REASONABLE COST OF PURCHASED SERVICES

214. REASONABLE COST OF PURCHASED SERVICES:

(A) Principle. The reasonable cost of purchased administrative services furnished under arrangements shall be an allowable cost, provided the services performed are necessary.

(B) Definitions.

(1) Reasonableness. Reasonableness shall require that the cost of the services:

a. be an amount that would ordinarily be paid for comparable services by comparable providers; and

b. be pertinent to the operation and sound conduct of the provider.

(2) Necessary. Necessary shall require that the function be pertinent to the operation and sound conduct of the provider.

(C) Application. (19 The Cabinet may establish criteria for use in determining the reasonable allowable cost of purchased services furnished by individuals under arrangements with a provider.

(2) If services are performed under arrangements on a full-time or regular part-time basis, the reasonable cost of these services shall not exceed the amount that would ordinarily be paid for comparable services by comparable providers to full-time or regular part-time employees plus a travel allowance.

(3) If services are performed under arrangements on a limited part-time or intermittent basis (less than fifteen (15) hours per week), the reasonable allowable cost of these services shall be the usual and customary charge for the service prevailing in the area plus a travel allowance.

(4) Costs shall be evaluated so that the costs shall not exceed what prudent and cost-conscious management would pay for the given service.

SECTION 215 - COST RELATED TO PATIENT SERVICES

215. COST RELATED TO PATIENT SERVICES:

(A) Principle. All payments to providers of services shall be based on the reasonable allowable cost of covered services under the programs and related to the treatment of beneficiaries. Reasonable allowable cost shall include all necessary and proper costs incurred in rendering the services, subject to principles which relate to specific items of revenue and cost. However, as provided in Section 217 of this manual, payments to providers of services shall be based on the lesser of the reasonable allowable cost of covered services furnished to program beneficiaries or the customary charges to the general public for these services.

(B) Definitions.

(1) Reasonable Allowable Cost. Reasonable allowable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used and the items to be included. These principles consider both direct and indirect costs of

providers of services. The costs with respect to individuals covered by the program shall not be borne by individuals not so covered, and the costs with respect to individuals not so **covered** shall not be borne by the program.

(2) **Necessary and Proper Costs.** Necessary and proper costs shall be costs which are appropriate in developing and maintaining the operation of patient treatment facilities and activities. They shall be costs which are common and accepted occurrences in the field of the provider's activity.

(C) **Application.** The determination of reasonable allowable cost of services shall be based on **cost** related to the treatment of beneficiaries under the program. Reasonable allowable costs, both direct and indirect, shall include all necessary and proper expenses incurred in rendering services, such as administrative costs, facility maintenance costs, and premium payments for employee health and pension plans. However, where the provider's operating cost

include amounts not related to patient services, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in **excess** of or more expensive than those generally considered necessary for the provision of needed services), the amounts shall not be allowable. The provider may require clarification of whether a particular cost item may be allowable and may request the advisement of the Cabinet. Upon receipt of all pertinent data regarding the item in question, the Cabinet shall take the matter under consideration and issue a response binding upon the provider and the Cabinet.

SECTION 216 - DETERMINATION OF COST OF SERVICES TO BENEFICIARIES

216. DETERMINATION OF COST OF SERVICES TO BENEFICIARIES:

(A) Principle. Total reasonable allowable cost of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program shall be based upon actual services received by program beneficiaries. The ratio of program covered units of service to total units of service shall be used to determine reimbursable program cost for those services by department or direct service cost center.

(B) Definitions.

(1) Apportionment. Apportionment shall mean an allocation or distribution of allowable cost between program beneficiaries and other patients.

(2) **Cost.** Cost refers to reasonable allowable cost as described in Section 215 of this manual.

(3) Average Departmental Cost Per Unit of Service. Average Departmental cost per unit of service shall mean the amount computed for each specified

department by dividing the total reasonable allowable cost for services rendered by the total number of covered units of service in the accounting period.

SECTION 217 - AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COST

217. AMOUNT OF PAYMENTS WHERE CUSTOMARY CHARGES FOR SERVICES FURNISHED ARE LESS THAN REASONABLE COSTS:

(A) Principle. Providers of services shall be paid the lesser of the reasonable allowable cost (as determined under these principles) of services furnished to beneficiaries or the customary charges made by the provider for the same services.

Exception for Title XIX: Public providers of service rendering services free of charge or at a nominal charge shall be paid actual reasonable allowable cost for services furnished to beneficiaries.

(B) Definitions.

(1) Customary Charges. Charges shall refer to the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services and who are liable for payment for services on the basis of charges. Charges for services rendered to beneficiaries shall be recorded on all bills submitted for program reimbursement. If the

provider does not actually impose charges in the case of most patients liable for payment for its services on a charge basis or fails to make reasonable efforts to collect the charges, customary charges for services rendered to beneficiaries shall be as follows: the charges as defined above and recorded on the bills submitted for program reimbursement, reduced in proportion to the ratio of the aggregate amount actually collected to the amounts that would have been realized had charges been consistent with the charges as defined above and paid by or on -behalf of all patients liable for payment on a charge basis.

(2) **Reasonable Allowable cost.** For purposes of comparison with customary charges, the reasonable allowable cost of services furnished to beneficiaries shall be the total possible annual payment based on established prospective rates before consideration of income.

(3) **Public Provider.** A public provider is any

provider operated by a Federal, State, county, city or other local governmental agency or instrumentality.

('4) **Nominal Charges.** A public provider's charges shall be considered nominal when the aggregate customary charges are less than one-half of the reasonable cost of services or items represented by the charges.

(C) **Aggregation of Charges.** On an aggregate basis, payments to a provider for covered services rendered beneficiaries under the program shall not **exceed** the customary charges made by the provider to the general public for the same services. The principle established shall be applied after the provider's charges and costs have been determined in accordance with the requirements set forth in these principles and shall have excluded costs and charges with **respect** to non-covered provider services.

SECTION 218 - LIMITATIONS ON ALLOWABLE COSTS

218. LIMITATIONS ON ALLOWABLE COSTS:

(A) Principle. In the determination of the provider's reasonable allowable cost, costs determined to be in excess of those necessary in the efficient delivery of covered services shall be excluded. These limitations may be made with respect to covered services, direct or indirect total costs, costs of specific items or services, or groups of items or services. These limits shall be applied prospectively when practical.

(B) Application. In determining the limits to be applied, providers or their costs may be classified by factors considered appropriate and practical.

(C) Data. In establishing limits, determination of the costs necessary for efficient delivery of covered services shall be based on cost report, utilization review data, or other data providing indicators of current reasonable costs.

(D) NOTICE OF LIMITS TO BE APPLIED. Prior to the onset of a cost period to which a limit shall be applied, the provider shall be notified of the limits to be applied to an identified cost and class of provider services. The following shall constitute notice of initial limitations to become effective with the implementation of the program.

(1) Reasonable Compensation. If professional services are rendered by full-time and regular part-time employees of the provider, the reasonable allowable cost of compensation of those employees shall not exceed the usual and customary compensation of employees performing similar services. Compensation includes salary, perquisites not routinely provided to other employees of the center, and maintenance provisions, whether in the form of cash payments or the fair value of in-kind benefits.

(2) Limitations Defined in Other Sections of This Manual. In the determination of the provider's reasonable allowable costs the limitations defined in other sections of this manual shall applicable.

219. PROVIDER REIMBURSEMENT REVIEWS AND APPEALS:

Participating providers shall be provided the following mechanism for a review of DMS's decisions relating to the application of the policies and procedures governing the AIS-MR payment system.

(A) A provider may request a review of any aspect of the payment system affecting reimbursement by writing to the Director, Division of Reimbursement Operations, DMS. If the issue to be reviewed relates to the cost report, this request shall be received within forty-five (45) days following transmittal of the final audited cost report to the provider; and shall indicate which adjustments the provider wishes to appeal. A blanket request to appeal the cost report shall not be accepted. Upon receipt of the request for review, the Director, Division of Reimbursement Operations, shall determine the need for a Department

and provider conference and shall contact the provider to arrange a conference if needed. The conference, if needed, shall be held within sixty (60) days of the request for review unless delayed due to extenuating circumstances. Regardless of the Department's decision, the provider shall be afforded the opportunity for a conference if desired for a full explanation of the factors involved and the Department's decision. The Director of the Division of Reimbursement Operations shall notify the provider of the Department's decision within twenty (20) days of receipt of the request for review or the date of the Department and provider conference, except that additional time may be taken as necessary to secure information or clarification pertinent to the resolution of the issue.

(B) If the Department's decision is unsatisfactory, the provider may then appeal the question to a Reimbursement Review Panel established by the

Commissioner of the Department for Medicaid Services. This Panel shall include one (1) member of the Division of Reimbursement Operations (DMS); one (1) member of the provider organization of their selection; and a member of the Division of Program Development and Budget (DMS). The Commissioner, Department for Medicaid Services, shall designate a member to serve as chairperson.

The request for review by the Reimbursement Review Panel shall be sent to the Director, Division of Reimbursement Operations, DMS, and be postmarked within thirty (30) days following the notification of the initial decision by the Director. The meeting date for the Reimbursement, Review Panel to consider the question shall be scheduled within twenty (20) days after receipt of a request for the appeal. The question shall be heard by the Panel and a decision, reached by vote of all Panel members, shall be rendered and issued within thirty (30) days, except

that additional time may be taken as necessary to secure information or clarification pertinent to the resolution of the issue. The decision shall be binding on all parties. In carrying out the intent and purpose of the program, the Panel may take into consideration extenuating circumstances which shall be considered in order to provide for equitable treatment and reimbursement of the provider.

SECTION 220 - REIMBURSEMENT FOR PROFESSIONAL SERVICES

220. REIMBURSEMENT FOR PROFESSIONAL SERVICES:

For the purposes of determining reasonable costs of professional services the following shall apply:

(A) With respect to full-time or regular part-time employees, the reasonable cost of these services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services.

(B) AIS-MR Residential care providers may contract for direct contact staff in family homes. AIS-MR Habilitation providers may contract for professional staff. No other direct care services shall be provided by contract by an AIS-MR provider. The reasonable cost of those services performed on a full-time or regular part-time basis shall not exceed the amount that would ordinarily be paid for comparable services by comparable providers to full-time or regular part-time employees plus a travel allowance. The reasonable cost of services performed on a limited part-time or intermittent basis shall be the usual and customary charge for the service prevailing in the area plus a travel allowance. *The* reasonable cost of all purchased services shall be determined in accordance with the provisions of Section 214 of this manual.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
ALTERNATIVE INTERMEDIATE SERVICES-MENTAL RETARDATION (AIS-MR) REIMBURSEMENT MANUAL

PART III

ANNUAL COST REPORT INSTRUCTIONS

CABINET FOR HUMAN RESOURCES
275 East Main Street
Frankfort, Kentucky 40621

PART III - TABLE OF CONTENTS

INTRODUCTION

INTRODUCTION:

These instructions are intended to guide Providers in preparing the annual cost report.

In completing the schedules, the period beginning and period ending, the provider name, identification number(s), and address shall be indicated on the cover page. Providers shall submit a cost report prepared on the accrual basis of accounting and otherwise consistent with generally accepted accounting principles.

SCHEDULE A: UNIT COST INFORMATION

301. Schedule A shall serve as the initial entry point for cost information into the Annual Cost Report. The expenses placed on Schedule A shall reflect the total expenses of the provider. Cost information shall be derived from the provider's accumulation of expenses by general ledger account type for each service or support activity cost center. Each provider shall, at a minimum, develop and maintain at least one (1) cost center to identify the expenses associated with each of the service or support activity cost centers listed on Schedule B.

In preparing Schedule A, workpapers shall be developed and maintained by the provider to explain all adjustments which are necessary to reconcile the provider's general ledger by service or support activity cost center information with the information that is placed on Schedule A.

Instructions:

Line # - This column is available for the cost report preparer to manually number each line of information consecutively for as many lines of information as shall be necessary.

SCHEDULE A: UNIT COST INFORMATION

Unit Code # - (Column 1) This column shall contain the provider's unique alpha or numeric identification for each service or support activity cost center.

Cost Center - (Column 2) This column shall contain the provider's designated title for each service or support activity cost center.

Columns #3-#8- Shall contain the expenses of the following specific general ledger account titles which shall have been identified with the service or support activity cost centers.

COLUMN #'(COST)	GENERAL LEDGER ACCOUNT TITLES
Column #3 (Personnel Costs)	PERSONAL SERVICES: * Salaries * Wages * Flexible Benefits-Child Care * Flexible Benefits-Medical Reimbursement * Flexible Benefits-Health Insurance * Flexible Benefits-Dental Insurance * Performance Incentive * Recognition Award * Fringe Benefits
Column #4 (Facility Costs)	FACILITY & SITE EXPENSE: * Telephone * General Liability Insurance & Fire Insurance * Moving Expense - Facilities * Building Usage Expense * Building Rental - External * Utilities * Program Off-Site Space Cost * Maintenance & Janitorial Supplies

SCHEDULE A: UNIT COST INFORMATION

COLUMN # (COST)	GENERAL LEDGER ACCOUNT TITLES
Column #4-Continued (Facility Costs)	REPAIR & MAINTENANCE: * Building INTEREST EXPENSE: * Building DEPRECIATION & AMORTIZATION: * Building
Column #5 (Travel & Transportation)	TRANSPORTATION & TRAVEL: * Travel Outside Region * Travel Outside State * Travel Within Region * Board Member & Volunteer Reimbursement * Gas & Oil * Client Transportation * Vehicle License Expense * Vehicle Insurance Expense * Vehicle Rental * Vehicle Rental - External * Miscellaneous REPAIR & MAINTENANCE: * Vehicles DEPRECIATION & AMORTIZATION: * Vehicles INTEREST EXPENSE: * Vehicles
Column #6 (Subcontracts)	SUBCONTRACTED SERVICES: * Payments to Subcontractors
Column #7 (Other Operating)	GENERAL & OPERATING EXPENDITURES: * Layout, Design & Typesetting * Office Supplies * Advertising (Letters, Newspapers, Electronic Media, etc.)

SCHEDULE A: UNIT COST INFORMATION

COLUMN # (COST)	GENERAL LEDGER ACCOUNT TITLE
Column #7-Continued (Other Operating)	GENERAL & OPERATING EXPENDITURES: * Recruiting * Subscription & Membership Dues * Licenses * Delivery Expense * Books * Advertising - Special * Office Equipment - Usage * Printing & Promotional * Postage * Printing (forms) * Professional Meetings * Training Expense * Out-of-State Training Expense * Cash Over/Short * Penalty Charges * Bank Service Charge * Loss Due to Theft * Administrative Charges * Annual Meeting * Annual Report * Miscellaneous PROFESSIONAL SERVICES: * Legal Expense * Data Processing * Audit & Evaluation * Miscellaneous Public Relations * Security Services SUBCONTRACTED SERVICES: * Direct Contact Staff - Family Homes * Professional Staff - [redacted]

SCHEDULE A: UNIT COST INFORMATION

COLUMN # (COST)	GENERAL LEDGER ACCOUNT TITLE
Column #7-Continued (Other Operating)	PROGRAM SUPPLIES & EXPENSES: * Fundraising - Usage of Funds * Dietary Supplies * Drugs * Laboratory Expense * Medical Supplies * Pharmaceutical & Supplies * Educational & Craft * Recreational * Food - Daily Meals * Laundry Expense * Client Personal Supplies * Client SSI Expenses * Miscellaneous REPAIR & MAINTENANCE: * Equipment * Other INTEREST EXPENSE: * Other DEPRECIATION & AMORTIZATION: * Other
Column #8 (In-Kind Expenses)	IN-KIND EXPENSE: * Services from Volunteers * Other Donated Goods & Services

Column #9 - Sub-Total - Add the information in column 3 through column 8 for each cost center.

Column #10 - Reclassifications & Allocations - Enter in this column the total of all "Local" reclassifications or allocations for each cost center which have been explained on Schedule A-l. (Indicate decreases or subtractions in brackets.)

SCHEDULE A: UNIT COST INFORMATION

Column #11 - Total - Add the information from column 9 to that from column 10 for each cost center.

Column #12 - Schedule B (Line # Reference) - Enter in column 12, the line number from Schedule B into which the cost of each individual cost center shall be forwarded. NOTE - It is neither necessary nor desirable to reclassify all similar cost centers to a single line prior to forwarding the cost information on to Schedule B.

SCHEDULE A-l: LOCAL RECLASSIFICATIONS AND ALLOCATIONS

302. Schedule A-l shall be to provide for the adjustments which may be necessary to properly allocate the expenses which may have been accumulated in local support activity cost centers to those service activity cost centers which they benefit. This schedule also provides for the allocation of service activity costs which may have been accumulated in a common cost center but which shall be separated to identify the cost of providing each service independently.

Instructions:

Line # - This column shall be available for the cost report preparer to manually number each line of information consecutively for as many lines of information as may be necessary.

Cost Center/Explanation - (Column 1) - Enter in this column, first, the titles of those cost centers which shall be affected by the adjustment and then, immediately below the titles, provide sufficient explanation of the purpose of the adjustment and the basis which was used for any allocations of cost.

WP Ref - (Column 2) - This column shall be available for the cost report preparer to manually cross-reference (index) workpapers which he shall have developed to explain all adjustments.

SCHEDULE A-l: LOCAL RECLASSIFICATIONS AND ALLOCATIONS

Schedule A - Line & Column - (Columns 3 & 4) - These columns refer to the line 'and column numbers of Schedule A into which the adjustment shall be forwarded.

Increase/(Decrease) - (Columns 5 & 6) - These columns shall contain the amount of the adjustment relating to each cost center.

SCHEDULE B: TOTAL ALLOWABLE EXPENSES

303. Schedule B shall be to summarize the cost information presented on Schedule A, to allocate organization-wide administrative and clinical support costs and to further adjust the provider's expenses to recognize non-reimbursable items of cost.

Instructions:

Column #1 - Total Costs - Enter in this column the summary total of costs from Schedule A, column 11, for each cost center as indicated in Schedule A, column 12. Example: the total cost of all cost centers from Schedule A, column 11 which also have line #20 indicated in Schedule A, column 12, are to be added together and their sum placed on Schedule B, line 20, column 1.

Column #2 - Adjustments - Enter in this column the total of all adjustments to cost from Schedule C, column 8 for each cost center.

Column #3 - Administrative Allocation - This column provides for the allocation of total allowable organization-wide administrative costs as determined by adding the information contained on Schedule B, line 1, column 1 with that on Schedule B, line 1, column 2 and placing this sum in brackets on line 1, column 3.

The allocation shall be accomplished by dividing the total allowable organization-wide administrative costs (Schedule B, Line 1, Column 3) by the total of Schedule B, column 1, less the information on lines 1 and 2. This will produce a "factor" which shall be entered in the space at the top of column #3 and which shall then be multiplied against each amount listed in Schedule B, column 1, except for lines 1 and 2, with the product of each of those multiplications being placed on the corresponding line in Schedule B, column 3, so that the total of column 3 will equal zero (0).

Column #4 - Clinical Support Allocation - This column provides for the allocation of total allowable organization-wide clinical support costs as determined by adding the information contained on Schedule B, line 2, column 1 with that on Schedule B, line 2, column 2, and placing this sum in brackets on line 2, column 4.

The allocation shall be accomplished by dividing the total allowable clinical support costs (Schedule B, line 2, column 4) by the total of Schedule B, column 1, less the information on lines 1 and 2. This shall produce a "factor" which shall be entered in the space at

the top of column #4 and which shall then be multiplied against each amount listed in Schedule B, column 1, except for lines 1 and 2, with the product of each of those multiplications being placed on the corresponding line in Schedule B, column 4, so that the total of column 4 will equal zero (0).

Column #5 - Allowable AIS-MR High Intensity Client Costs - Enter in this column, the amount of any "Special Needs" costs which shall have been incurred by the provider and approved for ancillary payment by the Department for Medicaid Services.

Column #6 - Total Allowable Expenses - Add the information from columns 1 through 4 for each cost center, then subtract the information from column 5.

SCHEDULE C: ADJUSTMENTS TO COST

304. Schedule C shall be to recognize those items of a provider's cost which shall not be reimbursable by the Cabinet and to summarize them by service cost center for subsequent adjustment on Schedule B.

The column descriptions indicate the more common activities which require adjustment. Types of items to be entered on Schedule C include: (1) those needed to adjust cost to reflect actual expenses incurred: (2) those items which constitute recovery of expenses; (3) those items specifically addressed in the Principles of Reimbursement (see: Part II of this manual); (4) those items specifically addressed by contract(s); and (5) those required to comply with applicable federal and state laws and regulations.

Instructions:

Column #1 - Out-of-State Travel - Enter in this column those expenses which shall be considered to be non-reimbursable based on Section 201(B)(11) of this Manual.

Column #2 - Bad Debts - Enter in this column those expenses which shall be considered to be non-reimbursable based on Section 208 of this Manual.

SCHEDULE C: ADJUSTMENTS TO COST

Column #3 - Interest Expense - Enter in this column those expenses which shall be considered to be non-reimbursable based on Section 207 of this Manual.

Column #4 - Management Vehicles - Enter in this column those expenses which shall be considered to be non-reimbursable based on Section 201(B)(13) of this Manual.

Column #5 - Program Income - Enter in this column those revenues which shall be to off-set against expenses based on Section 201(B)(15) of this Manual.

Column #6 - Restricted Donations - Enter in this column those grants or gifts which have been donor restricted (See: Section 211 of this Manual).

Column #7 - Other Non-Allowables - Self-Explanatory.

Column #8 - Total - Add the information from columns 1 through 7 for each cost center; and forward this sum to Schedule B, column 2 for each respective cost center.

SCHEDULE E: AIS/MR COST PER SERVICE

305. Schedule E shall be to calculate the cost per service for each of the prescribed fee-for-service cost centers.

Instructions.

Column #1 - Total Allowable Expenses - Enter in this column the total allowable expenses from Schedule B, column 6, for respective service.

Column #2 - Total Units of Service - Enter in this column the total units of service delivered without regard to payor for each respective service.

Column #3 - Cost per Unit of Service - Divide the allowable expenses shown in column 1 by the units of service shown in column 2 and place the resulting product in 'column 3 for each service.

SCHEDULE P: STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

306. Schedule P

(A) Section A shall be completed by all providers to show whether any of the costs to be reimbursed by the Cabinet includes any transaction for services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control.

(B) Section B shall be completed by all providers to show the total compensation paid for the period to corporate offices. Compensation shall be defined as the total benefit received (or receivable) for the services rendered to the organization. It shall include salary paid for managerial, administrative, professional and other services; amounts paid by the provider for the personal benefit of officers; and the cost of the assets and services which officers receive from the provider and deferred compensation. List each administrator or assistant administrator who has been employed during the fiscal period. List the name, title, percent of customary work week devoted to business, percent of the fiscal period employed, and total compensation for the period.

SCHEDULE P: STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

(C) Section C - Certification by Officer or Director of the provider. This statement shall be read and signed by an officer or director of the provider. Penalties may apply as stated in 42 U.S.C. Section 1320a-7b criminal penalties for acts involving Medicare or state health care programs.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
ALTERNATIVE INTERMEDIATE SERVICES-MENTAL RETARDATION (AIS-MR) REIMBURSEMENT MANUAL

PART IV

ANNUAL COST REPORT

CABINET FOR HUMAN RESOURCES
275 East Main Street
Frankfort, Kentucky 40621

PART IV - TABLE OF CONTENTS

DEPARTMENT FOR MEDICAID SERVICES

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION

ANNUAL COST REPORT

PROVIDER NAME

PROVIDER NUMBER

PROVIDER ADDRESS

PERIOD BEGINNING

PERIOD ENDING

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE A'

UNIT COST INFORMATION

PROVIDER NAME ______________________

FYE ______________________

LN #	UNIT CODE (1)	COST CENTERS (2)	PERSONNEL (3)	FACILITY COSTS (4)	TRAVEL & TRANS. (5)	SUB-CONTRACTS (6)	OTHER OPERATING (7)	IN-KIND (8)	SUBTOTAL (9)	RECLASS & ALLOC. INC/<DEC> (10)	TOTAL (11)	SCH B LN # REF (12)

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE A-1

PROVIDER NAME ____________________

LOCAL RECLASSIFICATION & ALLOCATIONS

FYE ____________________

	(1)	(2)	(3) SCHEDULE A	(4)	(5)	(6)
LN #	COST CENTER/EXPLANATION	W/P REF	LINE	COL	INCREASE	<DECREASE>

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE B

PROVIDER _____

FYE _____

TOTAL ALLOWABLE EXPENSES

LN #	Cost Centers	Total costs (1)	Adjustments (Sch C, Col 8) (2)	Administrative Allocation (3)	Clinical Support Allocation (4)	Less: Allowable AIS/MR High Intensity Cost (5)	Total Allowable Expenses (6)
1	Organization-Wide Administration						
2	Organization-Wide Clinical Supp.						
	AIS/MR						
3	Case Management(Intake Evaluation)						
4	Case Management (Core Cost)						
5	Case Management (Monthly)						
6	Residential Care - Group Home						
7	Residential Care - Family Home						
8	Individual Care - Staffed Residence						
9	In-Home Training						
10	Homemaker/Home Health Aide						
11	Personal Care						
12	Day Habilitation						
13	Respite - Hourly						
14	Respite - Daily						
15	Habilitation - Speech Therapy						
16	Habilitation - Occupational Therapy						
17	Habilitatioq - Physical Therapy						

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE B (Continued)

PROVIDER _____

FYE _____

TOTAL ALLOWABLE EXPENSES

LN #	Cost Centers	Total Costs (1)	Adjustments Sch C, Col 8) (2)	Administrative Allocation (3)	Clinical Support Allocation (4)	Less: Allowable AIS/MR High Intensity Cost (5)	Total Allowable Expenses (6)
	AIS/MR (Cont)						
18	Habilitation - Behaviour Specialist						
19	Habilitation-Leisure Trainer						
20	Habilitation-Psychological Service						
21	Habilitation-Expressive Therapy						
22	Habilitation-Therapeutic Recreation						
23	ADH Supported Employment						
24	ADH Prevocational Services						
25	Medical Items						
	Non-Reimbursable Cost Center						
26							
27							
28							
29							
30							
31							
32							
33	Grand Totals						

RLTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE C

PROVIDER _____ FYE _____

RDJUSTMENTS TO COST

LN #	Cost Centers	Out-Of-State Travel (1)	Bad Debts (2)	Interest Expense (3)	Management Vehicles (4)	Program Income (5)	Restricted Donations (6)	Other Non-Allowables (7)	Total (8)
1	Organization-Wide Administration								
2	Organization-Wide Clinical Supp.								
	AIS/MR								
3	Case Mgmt (Intake Evaluation)								
4	Case Mgmt (Core Cost)								
5	Case Management (Monthly)								
6	Residential Care - Group Home								
7	Residential Care - Family Home								
8	Individual Care-Staffed Residence								
9	In-Home Training								
10	Homemaker/Home Health Aide								
11	Personal Care								
12	Day Habilitation								
13	Respite - Hourly								
14	Respite - Daily								
15	Habilitation-Speech Therapy								
16	Habilitation-Occupational Therapy								
17	Habilitation-Physical Therapy								

RLTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE C (Continued)

PROVIDER _____ FYE _____

ADJUSTMENTS TO COST

LN #	Cost Centers	Out-Of-State Travel (1)	Bad Debts (2)	Interest Expense (3)	Management Vehicles (4)	Program Income (5)	Restricted Donations (6)	Other Non-Allowables (7)	Total (8)
	AIS/MR (Cont)								
18	Habilitation-Behaviour Specialist								
19	Habilitation - Leisure Trainer								
20	Habilitation-Psychological Serv.								
21	Habilitation-Expressive Therapy								
22	Habilitation-Therapeutic **Recreat.**								
23	ADH Supported **Employment**								
24	ADH Prevocational Services								
25	Medical Items								
	Non-Reimbursable Cost Centers								
26									
27									
28									
29									
30									
31									
32									
33	Grand Totals								

ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE E

AIS/MR COST PER SERVICE

PROVIDER NAME _____

FYE _____

LN #	Cost Centers	Total Allowable Expenses (1)	Total Units of Service (2)	Cost Per Service (3)
3	Case Mgmt (Intake Evaluation)			
4	Case Mgmt (Core Cost)			
5	Case Management (Monthly)			
6	Residential Care - Group Home			
7	Residential Care - Family Home			
8	Ind. Care-Staffed Residence			
9	In-Home Training			
10	Homemaker/Home Health Aide			
11	Personal Care			
12	Day Habilitation			
13	Respite - Hourly			
14	Respite - Daily			
15	Habilitation - Speech Therapy			
16	Habilitation-Occupational Ther.			
17	Habilitation - Physical Therapy			
18	Habilitation - Behaviour Spec.			
19	Habilitation - Leisure Trainer			
20	Habilitation-Psychological Ser.			
21	Habilitation - Expressive Ther.			
22	Habilitation - Therapeutic Rec.			
23	ADH Supported Employment			
24	ADH Prevocational Services			
25	Medical Items			
26				
27				
28				
29				
30				
31				
32				
33	Grand Totals			

ANNUAL COST REPORT
DEPARTMENT FOR MEDICAID SERVICES
ALTERNATIVE INTERMEDIATE SERVICES/MENTAL RETARDATION
SCHEDULE P

PROVIDER NAME: _____

FOR THE PERIOD BEGINNING _____ AND ENDING _____

A. STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

1. In the amounts to be reimbursed by the Cabinet, as reported on Schedule B, are any costs included which are a result of transactions with related organizations?

☐ Yes ☐ No

2.

Schedule	Line No.	Item	Amount

3. Name and percent of direct or indirect ownership of the related organization.

NAME OF OWNER	NAME OF RELATED ORGANIZATION	PERCENT

B. STATEMENT OF COMPENSATION PAID TO EXECUTIVE DIRECTORS, ADMINISTRATORS, OR ASSISTANT ADMINISTRATORS

NAME	TITLE	PERCENT OF CUSTOMARY WORE WEEK DEVOTED TO BUSINESS	PERCENT OF PERIOD EMPMYED	TOTAL COMPENSATION FOR THE PERIOD

C. CERTIFICATION BY OFFICER OR DIRECTOR OF THE PROVIDER

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE OR IMPRISONMENT OR BOTH UNDER FEDERAL LAW.

I HEREBY CERTIFYthat I have read the above statement and that I have examined the accompanying Annual Cost Report prepared by _____, for the period beginning _____ and ending _____, and that to the best of my knowledge and'belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions except as noted.

Signed _____ Officer/Director _____ Title _____ Date.